Abstract Requirements Mosa Conference 2018
AKO Phase 1 and Phase 4

In this document you will find all the information about submitting your abstract for Mosa Conference 2018 on **June 19th & 20st 2018**.

Key points for submitting:

- **Deadline: May 6th 2018, 23.59 h**
- Submission via two platforms:
  - Upload abstract at mosa-conference.nl → participants → submit abstract
  - Upload via SafeAssign in the map "Mosa Conference":
    Phase 1: Course 2017-100 AKO1018
    Phase 4: Organization AKO Fase 4 wetenschap in de zorg
- File name: [Last name_First name.docx]
- File format: Microsoft Word file (.doc or .docx)
- Written in English, max. 300 words
- A4 format, font Arial 11

Detailed instructions are given on the following pages and an example abstract is included at the very end of this document.
For extensive information about writing an abstract, we refer you to the article below.

Andrade, C. (2011). How to write a good abstract for a scientific paper or conference presentation. Indian journal of psychiatry, 2, 172–175.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3136027/

Good luck writing your abstract!

Abstract Requirements

Content requirements

- Language: The abstract should be written in the English language only.
- Word limit: The limit of the abstract is 300 words. Title and author are not included. Characters that are not in isonorm 8859-1 cannot be used. This means: α, β or other Greek characters need to be spelled out ("alpha" and "beta").
- Supervision: Names of student, supervisor(s) and institutional supervisor including affiliations should be stated on the abstract as well as the institute/location of the internship.

Style requirements

- File format: Microsoft Word file (.doc or .docx). Labelled: [Last name_First name.docx]
- Format and point size: Arial, size 11.
- Page Layout Guideline for A4: (21 cm x 29,7 cm) paper size. Page Layout should be as follows: Top – 3 cm, Bottom – 3 cm, Left – 3 cm, Right – 3 cm. This is important to ensure no text is lost when printing your abstract.
- Tables and figures: These can be added in addition to the abstract itself. The organization of Mosa Conference cannot guarantee that tables and figures will be placed in the book of abstracts.
- Refer to your university in English, example: 'Maastricht University'.

Important: Received abstracts that do not meet the submission requirements as described above will not be published in the book of abstracts.

Additional information

- Abstracts will be compiled in a (digital) book of abstracts.
- Note: In case your research project dealt with confidential material (e.g. IP, patent), please mention this (incl. the reason why it is confidential) in the mail when submitting the abstract. Please note that confidential abstracts will not be included in the abstract book.
- Abstracts will be judged and the five best abstracts will get an oral presentation at the conference with the possibility to win the price for best presentation. The five candidates will be informed via mail by the end of May
  Note: **All students have to prepare and present a poster**, including the ones who will give an oral presentation!

Choice between scientific abstract and review abstract

AKO students **Phase 4** need to write an abstract regarding their scientific work performed during their combi-Phase 4 internship. AKO students **Phase 1** may write a scientific abstract regarding current or previously (during Bachelor) performed scientific research, or they may choose to submit the "Jaarscriptie" abstract (review abstract). Description see next page.

1) Scientific abstracts should contain the following paragraphs:

- **Introduction:**
  Describes the current state of scientific progress regarding the scientific field. It should also contain the aim of the project and its scientific and/or social relevance.
- **Materials & methods:**
  Materials and methods used in the project should be described, such as a short summary of the study population (humans, animals), materials used (equipment, chemicals, etc.), how data was acquired (status, interviews, etc.) and which statistical analyses have been performed.
- **Results:**
  Contains findings and results of the project. A small table or graphic is possible. The results section should not contain an interpretation of the results!
- **Discussion & conclusions:**
  Presents the interpretation of the results and the conclusions drawn from the study. Furthermore, limitations of the study, implications for future studies and the consequences can be included.

2) Review abstracts should follow the format of the "Jaarscriptie" abstract:

- **Introduction:**
  Describe the burden of illness and fundamental aspects of the medical problem. The aim of your review and why it is important should be clearly stated.
- **Technological innovation:**
  In this paragraph, the novel technological innovation should be described in light of the medical problem.
- **Ethical aspects:**
  Highlight the relevant ethical and economical aspects of the new technology. This section should also contain the organizational aspects of implementing the new technology in daily medical practice. A small table or graphic is possible. Make sure to not reveal the conclusions yet!
- **Discussion & conclusions:**
  Present the conclusions of your review. Implications for future studies and further consequences should be included.

A GOOD ABSTRACT

The abstract of a paper is the only part of the paper

- that is published in conference proceedings
- that a potential referee sees when he is invited by an editor to review a manuscript
- that readers see when they search through electronic databases such as PubMed

Most readers will acknowledge, with a chuckle, that when they leaf through the hard copy of a journal, they look at only the titles of the contained papers. If a title interests them, they glance through the abstract of that paper. Only a dedicated reader will peruse the contents of the paper, and then, most often only the introduction and discussion sections. Only a reader with a very specific interest in the subject of the paper, and a need to understand it thoroughly, will read the entire paper.

Thus, for the vast majority of readers, the paper does not exist beyond its abstract. For the referees, and the few readers who wish to read beyond the abstract, the abstract sets the tone for the rest of the paper. It is therefore the duty of the author to ensure that the abstract is properly representative of the entire paper. For this, the abstract must have some general qualities. These are listed in **Table 1**.

Table 1

General qualities of a good abstract

The abstract is a condensed and concentrated version of the full text of the research manuscript. It should be sufficiently representative of the paper if read as a standalone document.
The abstract must be as detailed as possible within the word count limits specified by the journal to which the paper is intended to be submitted. This will require good precis writing skills, as well as a fine judgment about what information is necessary and what is not.
The abstract must contain as much information as possible on the analyses related to the primary and secondary outcome measures.
The abstract should not present a biased picture, such as only favorable outcomes with the study drug, or findings that support the authors' hypotheses; important nonsignificant and adverse findings should also receive mention. Thus, to the extent possible, the reader should be able to independently evaluate the authors' conclusions.

SECTIONS OF AN ABSTRACT

Background

This section should be the shortest part of the abstract and should very briefly outline the following information:

1. What is already known about the subject, related to the paper in question
2. What is not known about the subject and hence what the study intended to examine (or what the paper seeks to present)

In most cases, the background can be framed in just 2–3 sentences, with each sentence describing a different aspect of the information referred to above; sometimes, even a single sentence may suffice. The purpose of the background, as the word itself indicates, is to provide the reader with a background to the study, and hence to smoothly lead into a description of the methods employed in the investigation.

A longer background section means that less space remains for the presentation of the results. This is unfortunate because the reader is interested in the paper because of its findings, and not because of its background.

A wide variety of acceptably composed backgrounds is provided in **Table 2**; most of these have been adapted from actual papers. Readers may wish to compare the content in Table 2 with the original abstracts to see how the adaptations possibly improve on the originals. Note that, in the interest of brevity, unnecessary content is avoided. For instance, in Example 1 there is no need to state "The antidepressant efficacy of desvenlafaxine (DV), *a dual-acting antidepressant drug*, has been established…" (the unnecessary content is italicized).

Table 2

Examples of the background section of an abstract

The antidepressant efficacy of desvenlafaxine (DV) has been established in 8-week, randomized controlled trials. The present study examined the continued efficacy of DV across 6 months of maintenance treatment.
The healing powers of prayer have been examined in randomized, double-blind, appropriately controlled trials. However, no study has considered the philosophical pitfalls inherent in such studies.
Few studies have prospectively examined the musculoskeletal complications of unmodified electroconvulsive therapy (ECT)
The putative hypnotic benefits of melatonin have not been examined in patients with insomnia arising from medical causes.
Several tests are available to assess logical verbal memory. However, those standardized for use in India are short and simple; the result is a ceiling effect in young and highly educated samples.
The Eysenck Personality Inventory (EPI) was standardized for use in India, nearly 2 decades ago, in a linguistically and occupationally heterogeneous sample. The present study reassessed the findings of the original study in a purposive sample comprising urban, female, college students.
Women in India are traditionally housewives; however, in modern urban India, women are increasingly seeking jobs. Employment notwithstanding, women continue to be expected to discharge their traditional domestic duties. The likely result is role strain and impaired subjective well-being.

Methods

The methods section is usually the second-longest section in the abstract. It should contain enough information to enable the reader to understand what was done, and how. **Table 3** lists important questions to which the methods section should provide brief answers.

Table 3

Questions regarding which information should ideally be available in the methods section of an abstract

What was the research design?
What was the clinical diagnosis of the patients recruited?
What was the setting of the study (if relevant)?
How were the patients sampled?
What was the sample size in the whole sample and/or in the different groups?
What treatments did patients in different groups receive, and at what doses?
What was the duration of the study?
On what research instruments were patients rated?
What was the primary outcome measure and how was it defined?

Carelessly written methods sections lack information about important issues such as sample size, numbers of patients in different groups, doses of medications, and duration of the study. Readers have only to flip through the pages of a randomly selected journal to realize how common such carelessness is.

Table 4 presents examples of the contents of accept-ably written methods sections, modified from actual publications. Readers are invited to take special note of the first sentence of each example in **Table 4**; each is packed with detail, illustrating how to convey the maximum quantity of information with maximum economy of word count.

Table 4

Examples of the methods section of an abstract

Consecutive consenting male inpatients in moderately severe, uncomplicated alcohol withdrawal at screening were randomized to receive either lorazepam (8 mg/day; n=50) or chlordiazepoxide (80 mg/day; n=50) with dosing down-titrated to zero in a fixed-dose schedule across 8 treatment days. Double-blind assessments of withdrawal symptom severity and impairing adverse events were obtained during treatment and for 4 further days using the Clinical Institute Withdrawal Assessment for Alcohol revised scale (CIWA-Ar) and other instruments. The primary outcome was the trajectory of improvement in CIWA-Ar ratings.
Consenting adults (n=20) with severe, chronic, CBT- and antidepressant-refractory posttraumatic stress disorder (PTSD) were prospectively treated with a fixed course of 6 bilateral, twice-weekly, ambulatory ECT. The primary outcome measure was improvement on the Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS). Response to ECT was defined as at least 30% attenuation of CAPS ratings, and remission as an endpoint CAPS score of 20 or less.

Results

The results section is the most important part of the abstract and nothing should compromise its range and quality. This is because readers who peruse an abstract, do so to learn about the findings of the study. The results section should therefore be the longest part of the abstract and should contain as much detail about the findings as the journal word count permits. For example, it is bad writing to state “Response rates differed significantly between diabetic and nondiabetic patients.” A better sentence is “The response rate was higher in nondiabetic than in diabetic patients (49% vs 30%, respectively; P<0.01).”

Important information that the results should present is indicated in **Table 5**. Examples of acceptably written abstracts are presented in **Table 6**; one of them has been modified form an actual publication. Note that the first example is rather narrative in style whereas the second example is packed with data.

Table 5

Information that the results section of the abstract should ideally present

The number of patients who completed the study; drop out rates in the different groups in the study; in treatment studies, drop out rates specifically related to adverse events in each treatment arm.
The results of the analysis of the primary objectives, expressed in words along with P values in parentheses.
The results of the analysis of the more important secondary objectives, expressed in words along with *P* values in parentheses.
Numerical information about the above analyses, such as in terms of means and standard deviations, and response and remission rates. Wherever possible, effect sizes, relative risks, numbers needed to treat, and similar statistics should be provided along with confidence intervals for each.
Important negative findings, if any, should also be presented; that is, findings that fail to support the authors' hypotheses
Data on important adverse events should be included in addition to the data on efficacy

Table 6

Examples of the results section of an abstract

Three patients withdrew consent during week 1; all the rest completed the 6-ECT course. An intent-to-treat analysis (n=20) showed a significant fall in Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS) and HAM-D scores by a mean of 34.4% and 51.1%, respectively. Most of the improvement developed by the third ECT (day 10). The CAPS improvement was independent of the HAM-D improvement; and improvement in CAPS did not differ significantly between patients with less vs more severe baseline depression. The CAPS response rate was 70%; no patient remitted. In the complete analysis (n=17), mean improvements were 40% and 57% on CAPS and HAM-D, respectively, and the response rate was 82%. Treatment gains were maintained at a 6-month follow-up. No unexpected adverse effects were associated with treatment.
At the 7-year follow-up, 52,500 (74.9%) mother–child pairs were re-examined. attention-deficit hyperactivity disorder (ADHD) was identified in 945 (1.8%) children. Maternal [odds ratio (OR), 5.2; 95% confidence interval (CI), 3.4–9.1] and paternal (OR, 3.3; 95% CI, 2.0–5.8) ADHD were each associated with increased risk of ADHD in the offspring. ADHD was more common in male than in female children (OR, 4.8; 95% CI, 2.6–8.5). Maternal age, prematurity, low birth weight, fetal distress, and neonatal asphyxia were not associated with an increased 7-year risk of ADHD. After adjusting for maternal ADHD, intranatal exposure to psychotropic medication did not predict the 7-year risk of ADHD (OR, 1.2; 95% CI, 0.6–2.8).

Conclusions

This section should contain the most important take-home message of the study, expressed in a few precisely worded sentences. Usually, the finding highlighted here relates to the primary outcome measure; however, other important or unexpected findings should also be mentioned. It is also customary, but not essential, for the authors to express an opinion about the theoretical or practical implications of the findings, or the importance of their findings for the field. Thus, the conclusions may contain three elements:

1. The primary take-home message
2. The additional findings of importance
3. The perspective

Despite its necessary brevity, this section has the most impact on the average reader because readers generally trust authors and take their assertions at face value. For this reason, the conclusions should also be scrupulously honest; and authors should not claim more than their data demonstrate. Hypothetical examples of the conclusions section of an abstract are presented in **Table 7**.

Table 7

Examples of the conclusions section of an abstract

Desvenlafaxine (100–200 mg/day) is effective and well-tolerated in the attenuation of the number and severity of hot flashes in menopausal women; benefits are apparent within the first week of therapy and are maintained for at least 6 months of treatment.
Olanzapine (5–10 mg/day) augmentation improves illness and quality-of-life outcomes in selective serotonin reuptake inhibitor (SSRI) -refractory OCD; however, short-term weight gain and metabolic dysregulation in treated patients remain an important concern.
The 9.3% prevalence of bipolar spectrum disorders in students at an arts university is substantially higher than general population estimates. These findings strengthen the oft-expressed hypothesis linking creativity with affective psychopathology.
In contrast with previous research, our study found that lorazepam was as effective as diazepam on all outcome measures in patients with uncomplicated alcohol withdrawal. A likely explanation is that we used higher doses of lorazepam, and a longer treatment duration with a slower taper. We conclude that lorazepam can and should be preferred over diazepam in alcoholics with known or suspected liver disease.

Example of an abstract (submitted in 2015 to Mosa Conference)

Introduction

Multiple myeloma (MM) is a plasma cell disorder, characterized by an accumulation of malignant plasma cells in the bone marrow (BM). Despite the discovery of novel drugs, MM is still an incurable disease. The anaphase-promoting complex (APC) is an E3 ligase and contributes to cell cycle by ubiquitylation of cell cycle proteins such as securin and cyclin B and initiating anaphase. Genetic changes affecting APC and its regulator, the spindle assembly checkpoint, are described in MM patients and are associated with chromosomal instability and aneuploidy. The purpose of this study is to examine APC as a possible new target in MM.

Material and methods

The APC inhibitor proTAME (pT) was tested on human MM cell lines (HMCL) LP1 and RPMI, MM patient cells and stromal cells. Cells in metaphase were morphologically counted on May-Grünwald Giemsa stained cytospins using a light microscope. Viability and apoptosis was determined by respectively the CellTiterGlo assay (Promega) and Annexin V/7AAD flow cytometry staining. Expression of apoptotic and cell cycle proteins was determined by western blot. Statistical analysis was performed by the Mann-Whitney t-test.

Results

HMCL were treated with pT and mitosis was analysed by morphology. PT treatment induced a clear metaphase arrest that was accompanied by an accumulation of cyclin B which is consistent with APC inhibition. A prolonged metaphase can lead to cell death; therefore, we measured viability and apoptosis. We observed a significant dose-dependent decrease in viability and increase in apoptosis when HMCL and purified patient MM cells were treated with pT. In contrast, no effect on viability could be observed on other cell types from the BM micro-environment. PT had similar effects on MM cells when growth factors (IL-6 or IGF-1) or BM stromal cells were added to the MM cells, indicating that the BM micro-environment cannot abrogate the action of pT. We further analysed the apoptosis mechanisms by western blot and could clearly detect an increased cleavage of caspase 3, 8, 9 and PARP in MM cells treated with pT.

Conclusion

We can conclude that pT induces a prolonged metaphase in HMCL, resulting in reduced viability and induction of apoptosis that is accompanied by PARP cleavage and caspase 3, 8 and 9 activation. These findings suggest that the APC complex may be a promising target in MM.